Team Notes Prairie Island

July 15, 2010

1 = Face to Face (D-15)

2 = Self read

3 = Nice to know

JOURNEY TO ZERO

Site Event Free Days:

64

Inside this issue:

1

2

E-mail *Team Notes Prairie Island* articles to DL-PI-Communications by 10:00 a.m. the day before publication.

Safety Snippet of the Day 1

Unused hazardous materials, such as solvents, pesticides and motor oil, should not go into the ground, the garbage collection or the sewer system. For safety reasons, they shouldn't sit around too long awaiting disposal.

Today's Focus Area: Top Ten List item nearly complete 1

Equipment reliability improved through upgraded radiation monitors

The Engineering Change (EC 7776) package for the two atmospheric radiation monitors (R11 and R12) in Containment has been approved and installation is underway this week for Unit One and planned for early August for Unit Two. The installation will enhance equipment reliability at Prairie Island. The primary scope of this modification is to replace the existing radiation monitor skids, Control Room switches, indication, and analog readout meters with new equipment including digital display units and its associated software. The major tasks associated with this project include the following:

- Replace the existing Unit One and Unit Two monitoring skids.
- Remove old Control Room channel drawers and install new bin assemblies including digital rate-meters in the existing radiation monitoring rack locations.
- Modify the Simulator radiation monitoring racks to reflect new configuration.
- Add approximately 100 items to the equipment database.
- Add more than 140 engineering documents to the design database. Completed more than a dozen calculations.

The R11/12 skids contain two radiation monitors. R11 is a radiation monitor that detects particulate. It uses special paper to collect any particles and a detector (R11) to detect the level of radioactivity. Its paper drive has been unreliable and generates a "Paper not in motion" alarm frequently causing Limiting Condition of Operation (LCO) entries and operator distractions. R12 is a radiation monitor that samples the gases (air) to detect the level of radioactivity. These monitors notify the Control Room of radioactivity from the area sampled inside Containment. This is part of the required reactor coolant leakage detection system. Both the R11 and R12 monitors are obsolete which makes obtaining spare parts difficult and doing repairs even more difficult. The original equipment manufacturer no longer supports the equipment. These monitors are in operation 24 hours each day, 365 days a year to help ensure the health and safety of the public. The new installation will greatly increase the reliability and availability of

(Continued on page 2)

Picture of Xcellence

Plant ACEMAN Today ❶

A	**Accident Free**	👍
C	**Control Dose**	👍
E	**Event Free** *Reason:* The metal nozzle of a heat-shrink gun contacted an exposed electrical connection causing a short circuit and automatic transfer of 12 Inverter power supply. CAP#: 1241213 *Enablers Missed:* Planning/Preparation, Supervisor Oversight, Worker Practices.	👎
M	**Meet Commitments** *Reason:* Could not perform the boron sample Containment entry as 1R11 prevents environmental sampling prior to the entry. CAP#: 1241263 *Enablers Missed:* Job Planning/Preparation.	👎
A	**Attend Training**	👍
N	**No Rework** *Reason:* During fabrication of Radiation Monitor support, one hole was drilled in the wrong location. This required the support to be repaired. CAP#: 1241228 *Enablers Missed:* Worker Practices, Verification/Validation, Supervisor Oversight. *Reason:* Grouting activites did not meet the temperature requirements of Procedure D75. CAP#: 1241226 *Enablers Missed:* Procedures/Work Instructions, Worker Practices, Supoervisor Oversight.	👎

Plant Status ❶

Go to the Prairie Island Plant Status sheet for plant status.

R11/R12 *(Continued from page 1)*

the R11/12 skids. The equipment uses currently available technology and components. Many unplanned LCOs will be prevented with this modification. Some key milestones for the project are listed below.

Activity	*Status*
Design submitted for Final Design Review Board:	Completed
Final Design Review Board	Completed
Plant Operation Review Committee	Completed
EC Approved	Completed
Unit One skid installation	July 11-19
Unit One skid installation	August 2-9

The following groups will be working around the clock to support the project through its completion: Instruments & Controls, Quality Control, Radiation Protection, Operations, Project Management, Project Engineering, Warehousing, and Chemistry. Day & Zimmerman electricians and pipe fitters will also support the project.

Site leadership updates employees ❷

More than 600 employees and contractors met July 13 for Prairie Island's second All Hands Meeting this year.

Site Vice President Mark Schimmel and Site Operations Director Brad Sawatzke updated attendees on Prairie Island's performance, its current challenges, and its focus areas for 2010. They also used this opportunity to thank employees for their contributions to a successful refueling outage. "Your hard work and support during the 2R26 refueling outage demonstrates the teamwork and commitment necessary to continue making station improvements." said Schimmel.

Highlights of the meeting included:

- 2R26 Outage updates on safety, Human Performance, accomplishments and lessons learned.
- NRC and INPO interface with findings, inspections, regulatory conferences, license renewal.
- Discussion on the three-phase approach to site improvements.
- Updates on the 2010 site focus areas of Human Performance, Equipment Reliability, and the Corrective Action Program.
- Nuclear Safety Culture Assessment results.
- Using the Picture of Xcellence to guide actions.

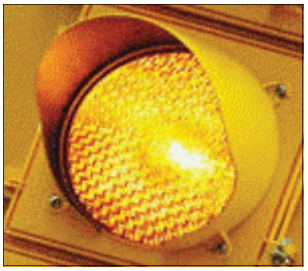
Schimmel stressed the importance of the site gathering regularly for All Hands Meetings to allow the organization to work effectively. The next All Hands Meeting is scheduled to be held in September. A link to the All Hands meeting presentation is on the PI Net home page.

CAP process improved

Edward Malarkey, Nuclear Passport Software Product Manager

For many people working at Xcel Energy nuclear sites, writing a CAP can seem a daunting challenge. Much time and frustration could be saved if, instead of stepping through several PassPort screens to write and submit a CAP, one could simply click on a web link from any computer station, zip through a few questions and automatically generate and submit a CAP for approval. Furthermore, if the condition identified was due to an equipment or system failure and the related and cross-referenced work request could also be auto-generated at the same time, it would enhance efficiencies even more. The answer lies in the Single Point of Entry (SPOE) Wizard which is currently in a pilot phase at Monticello and Prairie Island. This is the first effort to create a simplified process using the new tools available in PassPort Foundation Architecture. The SPOE Wizard allows the user to create a CAP by answering a few simple questions and has the ability to create an associated Work Request linked to a piece of equipment. Both can be routed automatically to the appropriate individual or group. The entire process is outlined in the Foundation Architecture User Guides. Fleetwide deployment is scheduled for July 21. The SPOE Wizard does not replace the current practice of writing CAPs and WRs. This is an alternate means to input the same information. Whether logging onto PassPort or using the Foundation Architecture link, the information goes to the same place. For additional information, please contact Lori Engesser or David Garcia.

STOPLIGHT on Human Performance



The site stoplight was changed to yellow yesterday. The following information is preliminary and may not be complete; it is intended for the purpose of disseminating as much information in as short amount of time as possible in order to prevent similar incidents from occurring.

Incident: During the installation of 1R11 Radiation Monitor 12, the instrument inverter transferred to the alternate source causing entry to an unplanned Technical Specification Action Statement.

Date: July 13, 2010

CAP#: 1241213

Description: While installing wire labels for the new radiation monitor 1R11, the metal nozzle of a heat-shrink gun contacted an exposed electrical connection. This caused a short circuit and automatic transfer of 12 Inverter power supply. The unplanned transfer of 12 Inverter to the alternate source resulted in a Technical Specification Action Statement being entered.

What went wrong? A Pre-job brief was conducted prior to commencing work. The Pre-job Brief was inadequate in that electrical insulating barriers were not identified as required to prevent inadvertent contact with known exposed and energized components in the cabinet. Additionally, a breakdown in worker practices occurred because the workers did not stop when the heat gun was observed to be in close proximity to unprotected energized terminals.

What went right? Workers immediately stopped work, placed equipment in a safe condition, and contacted operations when the heat gun contacted the terminal. All subsequent actions were performed in accordance with procedures.

Takeaway Message: Pre-job Briefs and job site hazard analysis should include the identification and use of robust barriers to prevent or mitigate

Nothing is routine

When a task appears to be routine - STOP! Take time to consider what could go wrong. Even though it may seem routine, it does NOT mean there are no risks involved.

The Practicing Perfection Institute defines a questioning attitude as: "An engaged state of mind that challenges given conditions to identify discrepancies in the status quo that might result in error or inappropriate action." Visit When Mistakes are not an Option for additional information.

Industry OE ❷

Subject: OE30952 unexpected induced voltage encountered

Plant: Millstone

Event Date: 02/03/2010

Description: 120vac was introduced into a newly constructed DC circuit without other affected department personnel being aware. The Conduct of Maintenance Job Briefing procedure states job briefings are mandatory and "are provided as an aid for all types of maintenance work, and with any number of workers or departments involved in the work." All affected personnel were not involved in the pre-job brief. Further investigation indicated there was 120vac on the affected leads. The new wiring was traced back into the upstream control panel for the new "C" transformer. From there the 120vac was traced from the control cabinet and into the T-medic cabinet. The "C" T-medic cabinet was opened and there a two-wire jumper from the AC supply breaker to the DC supply breaker was found. The T-medics cabinets on all three new transformers had jumpers installed from the AC supply breaker to the DC supply breaker. Each jumper has a manila tag indicating it was installed back in the fall of 2009 by test personnel.

Cause: The failure to involve all personnel in the pre-job brief. There should not have been any live voltages introduced into any new circuit without the clear communication from the testing department to the construction crew installing the cabling for the new circuits. Prior to energizing portions of new circuits, the testing department should have clearly communicated their intent to the construction crew and any other potentially affected personnel and verified there was no conflict. Once testing was complete, the testing voltage should have been removed and declared safe. This should have also been clearly communicated to all affected pThe Practicing Perfection Institute defines a "questioning attitude" as: "An

The Right Picture ❷

Pictured below is an example of a sign that was placed over a confined space entry sign. Confined space signs are clearly marked as "danger" as seen in the second photo. Danger signs should NEVER be covered with another sign or any other object. If the space available is unable to accommodate additional signage, contact the Safety Department consultants for assistance.

The WRONG picture for signage.

The RIGHT picture for signage.

Coworker Coaching ❷

Last week's Human Performance Tool of the week was Coworker Coaching. Below are some examples from recent ***I Care*** cards of how this tool was used to coach one another to prevent injuries and events.

- Coached operators on the locations of hot feed-water piping.
- Coached person to use handrail on steps and not to skip steps.
- Reminded a person to use gloves while adjusting a file cabinet.
- Coached a person working outside to use sun screen.
- Coached a person to remove trip hazard that had been place in the walkway.
- Coached a person who had not completed all the fields on a work request.
- Coached a person to place glove in the SAM before clearing Access Control.

Everyone should take a minute or two to fill out an ***I Care*** card after coaching or being coached by someone. Coworker coaching helps achieve positive results in all the ACEMAN categories.

Laptop locks ❷

IT currently is striving to fully comply with Xcel Energy Corporate Policy 9.20 requiring users of laptops to physically secure them when left unattended. To obtain a laptop lock, please contact Betsy McMorrow at extension 4700. The laptop lock cables may be placed around desk supports or legs. Periodic walkthroughs will be conducted to ensure full compliance with this policy. For additional information about this policy, please contact Rick Schuster at extension 7314. The policy is available on XpressNet.